INDUSTRIAL MEDICAL COUNCIL

Medically Speaking

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Council Announces Second Educational Conference

The Industrial Medical Council has set October 3, 1998 for its second Educational Conference for Treating Physicians (ECTP II).

The conference will be held at the Westin South Coast Plaza Hotel in Costa Mesa, Orange County. The format and content will be similar to the first conference with some new speakers added and new subject matter to be addressed. The conference will again be directed toward treating physicians new to workers compensation, those who do a small volume of WC patients, or physicians wishing to improve upon their skills and knowledge in this complex system.

ECTP I held in South San Francisco on 20 Nov '97 was an unexpected overnight success story. "Our first attempt brought an overwhelmingly positive response," said Dr. Allan MacKenzie. The conference will be held on a Saturday and according to Dr. MacKenzie will be a full day of quality instruction.

Over the past several years, a number of new laws have affected the way physicians work within the compensation system. Although many concepts such as apportionment and AOE/COE have remained constant, many areas such as timeframes, reporting requirements and disclosures have been changed. The ratings schedule has also been modified. This year, changes are also expected in the reporting requirements for treating physicians.

For more information, call the IMC at 1-800-794-6900. Audio tapes and the syllabus from the first conference are still available for $25.

IMC Amends Cardiac & Pulmonary Guidelines

Under the guidance of Dr. Jonathan Ng, MD, the IMC has updated and amended two disability evaluation guidelines - Guidelines for Evaluation of Cardiac Disability (§45) and Guidelines for Evaluation of Pulmonary Disability (§44). The new guidelines become effective July 19, 1998. The majority of the existing text of each guideline was retained without change. Here are the highlights of the changes:

Evaluation of Cardiac Disability

The IMC added Table 4 to the guideline as a guide for estimating minimum work preclusions on the basis of current work levels, when it is not feasible to determine pre-injury work level. Also, on page 16, there is new wording under the example of how to calculate the percentage of impairment from the METS, pre- and post-injury. Wording was added to allow the physician to take into account the fact that mere survival requires 2.5 METS. One other table was added to the guideline, which includes the new work capacity guidelines for dates of injury after April 1, 1997.

Guidelines for Evaluation of Pulmonary Disability

This guideline has changes in the guideline tables and a new algorithm. The algorithm provides a step-wise approach to determining if asthma is likely and for further classification of the impairment. **con't on p.6**

IMC Treatment Guidelines

Last year, the IMC adopted as regulation, ten treatment guidelines to supplement the already existing treatment guidelines for occupational asthma and contact dermatitis. This harvest included guidelines for the treatment of Post-Traumatic Stress Disorder, and problems of the cervical spine, low back, shoulder, elbow, hand and wrist (including de Quervain's Tenosynovitis and Carpal Tunnel Syndrome) as well as knee.

The guidelines were the result of a concerted effort among the many specialty groups within the workers compensation community to introduce physicians new to the system and those experienced in the evaluation and management of occupational illness and injuries.

The guidelines contain an introductory section, "Scope of the Guideline," which lays out the specific intent of the guidelines. Their chief purpose is to provide physicians with a practical framework to approach the treatment of *common* industrial injuries. In a sense, they have become the Council's strong recommendations as to which assessment and treatment methods best "cure or relieve" the effects of a workplace injury.

They were *not* created to serve as the basis for imposition of civil professional liability or professional sanctions. They are also not intended to be used as the sole basis for denial of treatment authorization or payment. They also do not address legal causation or work relatedness (COE).

It should be noted that the Council's recommendations are based on direct input **con't on p. 3**

AD Seeks IMC's Help On New Fee Schedule

Mr. Casey Young has requested the IMC to formally assist him in the preparation of the new fee schedule. The current fee schedule has been a work-in-progress for nearly two years and has already received voluminous public comment. Dr. Allan MacKenzie reported to the fee schedule committee at the May IMC meeting that he would consider providing administrative support to Mr. Young provided Mr. Young make the request in writing and that Mr. Young retain full authority over policy issues on the fee schedule. For future fee schedules, one alternative being studied is the Medicare RBRVS System as a potential replacement for the current fee schedule. This is still in the developmental stage.

Councilmember Richard Sommer expressed his disappointment over the delays in the implementation of the fee schedule to the committee and it was agreed that a work plan could be devised to ensure that the schedule be completed in the next several months.

EMD Viewpoint

By: D.A. MacKenzie, MD, FAAOS

Greetings from the IMC. I hope that everyone has survived the ravages of El Nino and is preparing for a prosperous, and hopefully, a dry summer ahead. I have a few items of interest.

First, I wish to once again thank departing Councilmember Rebecca Cohn for all of her work on the Council these past few years. Rebecca's work on the education committee and the contracts committee helped the Council sort out more than a few red herrings. She will be missed by us all.

In her slot, we welcome Patricia Sinnott, PT, MPH to the Council. Patricia has already begun preliminary work for the Council's Continuous Quality Improvement of the treatment guidelines.

I am also happy to report the hiring of Mr. Gerry Evans as the IMC's new Senior Special Investigator. We have for some time been hoping to continue working on our pending investigations but were somewhat stymied by the lack of personnel for follow-up work. Mr. Evans has more than 30 years experience with the San Francisco Police Department and private investigation. He brings outstanding qualities to the complaint tracking unit. We are fortunate to have him and we welcome him on board.

Regarding the QME process, we are continuing to improve our reappointment system. I believe the link with the Medical Board's new home page will make the process much more expedient. This will allow staff more time to deal with more sophisticated work.

As always, if you have any questions or problems dealing with the QME systems, please feel free to call on our staff or me at anytime.

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RANDOM NOTES

☛ The Council has approved Life Chiropractic College -West as a provider for workers' compensation certification (sometimes referred to as Industrial Disability Evaluation) for doctors of chiropractic seeking to become Qualified Medical Evaluators. Life West joins the four existing approved providers: California Chiropractic Assoc; Cleveland Chiropractic College - LA; International Chiropractic Association of California; and the Los Angeles College of Chiropractic to test and certify applicants.

☛ The IMC Chiropractic Advisory Committee has also approved several amendments to the existing IMC regulations §13.5 concerning IDE certification. The new regulations, which will be noticed for public hearing prior to adoption, require a minimum number of class hours (44) including an initial eight hours of overview of the workers' compenstion system. The hours will be transferable to any other program provider. Instructors will be required to have at least two years experience in the area of workers' compensation issues. Notices for the hearings will be sent out in the coming weeks.

☛ After noting the proliferation of such programs across the country, the Council has begun preliminary work on a policy statement with respect to modified work programs. The policy statement will be presented to the Commission on Health and Safety and Workers' Compensation upon completion. Further work on this issue is anticipated. The Council is interested in hearing opinion and comment from the Workers' Compensation Community on this important issue.

☛ For those QMEs whose reappointment are due, he or she should submit a complete reappointment application that would include a copy of completion of 12 hours of CME credit, current license to practice, and QME annual fee.

cont'd from p. 1 -- Treatment

from each specialty group, payors and injured workers and attorneys involved in the workers' compensation community. This process is called "consensus," and somewhat unfairly, has been labeled pejoratively. In point of fact, the final product was the result of three and a half years of public meetings and hearings, and critical analysis of all current medical scientific evidence along with Council discussion and debate.

The guidelines currently cover almost all relevant treatment considerations in the acute (up to 30 days) and the subacute phase (31-90 days) of the treatment timeline.

Ask and Ye Shall Receive?

Labor Code §4600 provides the employer with the affirmative duty to provide *reasonable* treatment to cure or relieve (there's that phrase again) from the effects of a work place injury. Unfortunately, the process of obtaining treatment authorization is sometimes difficult because of the complexity of the medical issues that may arise in an injured worker's case. This complexity generated some controversy in the Workers' Compensation Community. On one hand, payors expressed their opinion that the guidelines did not go far enough with respect to cost containment. Conversely, some providers were opposed to the fact that limitations were placed on the extent of assessment procedures such as routine X-rays, and the frequency of treatment. As one can imagine, the IMC was not in an enviable position with respect to carving out a happy medium.

Moreover, there are many published cases and board decisions dealing with what is "reasonable" as far as treatment. Experience tells us that what's reasonable is usually the amount a payor is willing to pay on a lien and the amount the provider is willing to accept. The IMC however, was unable to use this "definition" to determine reasonableness under §4600.

As a result, the Council created four levels of appropriateness of treatment methods, with level four being the highest. This is based on what the research evidence and community consensus had proven efficacious. If a treatment modality has sound scientific evidence, good clinical evidence and strong community consensus, then that treatment rates a four. However, if a treatment has little scientific, clinical, or consensus support, it rates a one. A physician can also vary from the guidelines. This situation is considered under appropriateness level two which allows that the'varied' treatment is appropriate in uncommon instances and that the need be clearly documented by the provider. Although the guidelines address specific types of injuries, the scope section and format apply to all of the guidelines.

Initial Assessment and Treatment

The specific goal of the **initial assessment section is** to establish a working diagnosis. Generally, taking a history and doing a physical examination will accomplish that aim. The guidelines preclude the *routine* use of lab studies and x-rays unless worrisome or serious medical conditions are present. For example, in the low back guideline, routine EMGs and the like are considered inappropriate methods to initially assess a work injury.

Appropriate initial treatment methods considered efficacious include education, workplace modification, exercises and certain medications when indicated. Physical treatment is appropriate and may be supplemented by passive modalities, including acupuncture, as documented by the provider.

Secondary Assessment and Treatment

During the second/third months, the guidelines provide different approaches to assessment of injury including, x-rays, other diagnostic imaging tests, lab tests, EMGs and psychological assessments. Inappropriate secondary methods generally include surface EMG and discography/diagnostic blocks.

In the secondary period, the aim of treatment is to provide symptomatic relief with the overall goal of **return to work**. Physical treatments, acupuncture, TENS and certain medications if indicated, may be appropriate in this phase of treatment for severe or exceptional injuries.

Within six months after treatment has begun, the guidelines suggest that providers should document whether further treatment remains necessary and whether the patient continues to have subjective and objective problems associated with the injury. Since all patients are not identical, there is allowance for variance from the guideline as long as the provider believes that the variance is within accepted standards of practice and the need for the variance is explained and clearly documented.

It is the Council's hope that, overtime, these guidelines will be accepted by both payors and providers as best 'practices' and reflect the mainstream community's point of view. As with any set of guidelines though, there remains the need for continuous monitoring and periodic updates to ensure that the parameters remain consistent and current with medical scientific evidence. The guidelines are available now on the internet www.dir.ca.gov and through the IMC **1-800-794-6900**.

AVOIDING CONFLICTS OF INTEREST

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Physicians must be aware of a potential conflict of interest when they have dual relationship with a patient both as an attending physician and as an independent consultant. A patient enters into a doctor-patient relationship with a physician when he or she asks the physician to provide medical care. By virtue of this relationship, the patient is entitled to assume that the physician will protect the confidentiality of all medical history and information, and will not disclose such information without the patient's authorization.

No doctor-patient relationship ordinarily exists when a physician agrees, on behalf of an attorney, insurance carrier or employer, to conduct only an "independent medical examination." Sometimes a physician is retained by an employer to conduct an independent pre-employment examination or a post-accident evaluation of a person who also happens to be the examining doctor's patient.

Written reports by the examining physician in these circumstances are not part of the patient's medical record, and ordinarily are sent only to the party who requested and is paying for the evaluation. To avoid conflicting responsibilities and patient protest, the physician should obtain and document the requesting party's consent to disclosure of examination results to the patient. If, during the exam, the physician identifies a medical condition that requires treatment, the physician should inform the patient.

In some situations, a physician who has an established doctor-patient relationship with an individual may not be able, without risking a conflict of interest, to serve as an independent consultant for an attorney, insurer, employer or other third party. A physician who attempts to serve in dual capacities as a patient's attending physician and as an independent examiner of the patient on behalf of a third party may find it impossible to protect the confidentiality of information the doctor learned in confidence in his or her capacity as the patient's physician.

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Community Viewpoint

Disability Evaluation and Ratings - A Perspective

By : Steven D. Feinberg, MD & Luis Perez-Cordero, PD Ratings Specialist

The Community Viewpoint is intended as a forum for interested persons to comment and give opinion on issues affecting the Workers' Compensation Community.

This article will discuss the physician's responsibility to describe the injured worker's disability in terms of residual loss of work capacity due to the industrial injury. The physician's role as evaluators is to fairly and accurately describe the injured worker's disability and associated work preclusions which are consistent with objective physical and neurological findings.

Permanent Disability

Permanent Disability is the benefit that compensates an injured worker for the residual effects related to loss of work capacity from an industrial injury. The "residual effects" from an industrial injury could include the partial or total loss of a part of the body or its anatomical function as compared to its previous level of functioning. In California, there is only a ratable disability if it causes an actual reduction of work capacity or function.

In determining permanent disability, the following is taken into account: (1) the occupation and age of the injured worker at the time of the injury; (2) the nature of the physical injury or disfigurement; and (3) the diminished ability of the injured worker to compete in the open labor market. These last two factors are to be described by the physician.

Permanent Disability is a 'numeric representation' of the degree to which the permanent effects of the injury have diminished the capacity of an employee to compete for and maintain employment. This 'numeric representation' is based on the medical findings and conclusions addressing permanent impairments and limitations, whether objectively measurable (such as amputation or motion loss), subjectively measurable (such as loss of endurance or disabling pain), or measured by work functional loss (work preclusions) and/or the need of a brace or appliance. The work preclusions suggested are warranted either because the employee can not perform a function or group of functions, or should not perform functions in order to prevent further injury."

Evaluating Disability

The physician does not provide a percentage rating," but rather defines the medical disability and how it affects the injured worker's ability to compete in the open labor market. Physicians describe disability in terms of physical losses of function that are (1) directly measurable (Objective Factors); (2) in terms of the disabling effects of pain (Subjective Factors); or by (3) referring to the loss of work capacity or work function as expressed by either a percentage of loss or a work restriction.

The physician's evaluation takes place when the employee's condition stabilizes and becomes permanent and stationary (P&S) or reaches the point of "maximum medical improvement." Permanent and stationary does not imply that there is no room for the natural waxing and waning course of many diseases, but rather that the illness has reached a plateau and that the condition has stabilized. Once the patient is P&S, a rating specialist then interprets the disability information provided by the physician and turns that information into a numeric representation of permanent disability.

Objective Factors of disability are physical changes or loses in function that are directly measurable, such as, motion loss, amputation, strength decrement, etc. The prevalent method of measuring physical elements of disability is contained in *The Evaluation of In-*

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Reimbursement For Specific Reports

By : Gary N. Miller, DC, FAFICC

Over the past several years and due to the changes in the Labor Code and reporting requirements, some confusion has developed with regard to how the provider should receive reimbursement for specific reports. I hope the following will provide clarification in order for the QME actions as a Primary Treating Physician to bill and receive appropriate reimbursement for his or her services.

Separately reimbursable treatment reports would include the Final Treating Physician's Report of Disability Status (DWC Form RU-90). Payment for this report is reimbursable only when the physician renders an opinion concluding that the employee's injury is likely to permanently preclude the employee from returning to the pre-injury occupation. This report charge is payable in addition to the underlying evaluation and management service for an office visit. The CPT code is 99080 (Special Reports) and is reimbursable at $39.98 using the medical conversion factor at 6.5 relative value for one page.

There are occasions when the primary treating physician is required to review a patient's RU-91 and/or a formal written Job Analysis. Review of the RU-91 is not reimbursable. However, if review of the patient's formal Job Analysis and/or other records requires the physician to spend 30 minutes or more, and if there is no direct (face-to-face) contact, he/she may bill a prolonged service code 99358. The physician is not entitled to charge for an EM code, however, if a report is also required, then the CPT Code 99080 for report charge would be appropriate. The first page of all special reports should be billed at $39.98 and subsequent pages 2 through 6 are billed at $24.60. Maximum reimbursement for special reports is 6 pages.

There are occasions when a physician is required to review a formal Job Analysis and/or an RU-91, and this information may differ from the patient's interpretation of their own job duties. This situation may require that the doctor review records and write an opinion, for which he may also bill a prolonged service code and a report code. It has been my experience that if providers communicate with claims adjusters **in advance** in regard to the necessity for these reports, there will be a greater likelihood for reimbursement.

I hope the aforementioned information will be of benefit to physicians for obtaining reimbursement of the extra time we spend communicating information.

(Dr. Miller has been a QME since 1991)

cont'd from p. 4--Permanent

dustrial Disability edited by Packard Thurber.

Subjective Factors are characterized in terms of body part affected, intensity, frequency, and the activity giving rise to the pain. The Subjective Factors described by the physician are then considered by the rater as part of the overall numeric representation of the permanent level of disability. The physician must always describe the pain's etiology and the worker's complaints and give an opinion regarding soundness and the reasons for their conclusions. The relationship of the reported pain to the underlying pathological process should be clearly delineated within the bounds of medical probability with the physician describing of how the symptoms affect performance/ability to work rather than how severely the symptoms are perceived. It is important for the physician to remember that the reiteration of the patient's complaints is not considered subjective disability. The evaluator is responsible for the proper description and assessment of disability related to the pain not predicated on intensity or frequency alone, but related to its disabling impact on function.

Work Capacity : Work Restrictions

In addition to objective and subjective factors of disability, the physician may describe work preclusions. Work preclusions, by definition, establish limits of specific activities or tasks which impede, restrict, prevent, limit, control or avoid an activity, body position or motion, and help prevent exposure to chemicals, substances, heat, etc. Their need must be clear, realistic and consistent with the clinical findings.

The State of California Schedule for Rating Permanent Disabilities states that "disabilities may be expressed in terms of limitations of work activities." The schedule provides a framework of work capacity guidelines for various body parts, but the physician is not limited to those descriptions. It is the physician's responsibility to clearly state the specific work preclusions for each particular injured worker. If the Schedule has work preclusions that fit, then use it, but otherwise the schedule is best thought of as a guideline. The physician should not hesitate to describe the reality of the situation for the injured worker and list the true work limitations for that individual. The physician should accurately and fairly describe the injured workers' inability and loss to perform work-related functions. A corresponding percentage of pre-injury capacity functional loss can help physicians in that their description of disability is not overstated or undervalued.

Work Capacity : Functional Loss

In addition to defining loss of work capacity as a function of work preclusions, the physician may also describe percentage loss of function or proportionate loss to perform specific functions. The physician describes the loss in relative terms; that is, the disability is presented in terms of a percentage loss of pre-injury for the specific individual. This can be a particularly useful approach as it is user friendly to physicians, who can easily discuss loss of capacity. For example, the injured worker has lost half of his pre-injury capacity for lifting, bending and stooping [due to a spinal disability]. Or for an injured dominant hand the physician could state that the injured worker has lost 50% of both hand strength and finger dexterity function.

Loss of pre-injury work capacity can be estimated broadly in three main levels addressing the 25%, 50%, and 75% levels of functional loss. The physician must be precise, as to which body part (nature of physical injury) the percentage of pre-injury capacity applies since vagueness and incompleteness leads to costly disputes as to what you intended to say. Don't just say the injured worker has a 50% loss if functional capacity. If the impairment you are describing is for the wrist joint, say so! It is one thing for all functions of the wrist joint and another to "interpret" yourstatement to mean a 50% loss for all functions of one or both upper extremities

Physicians Describing Disability

We propose that physicians can do a better job in satisfying the needs of the California Workers' Compensation System if they describe work preclusions or loss of work capacity particularly if they are unfamiliar with the WCAB Guidelines. Physicians must always make sure that the loss of work capacity and imposition of work preclusions described in their medical reports is based on sound medical opinion consistent with the objective physical/neurological findings.

For the **Spine/Torso**, functional loss can be describe for either a specific function or group of functions including such activities as bending, stooping, lifting, pushing and climbing or other activities involving comparable physical effort. [The Schedule, pages 2-14 to - 2-15]

Generally, in disabilities involving the back, you will find there are four major elements to be considered. They are limitation of motion, disabling effects of pain, weakness and endurance. Although not as common as the aforementioned, when supported by medical/clinical findings, additional factors can also be considered, such as avoidance of prolonged stationary positioning, impairments of bowel or bladder incontinence and manifestations of objective physical impairments in the upper/lower extremities.

These additional factors are usually due to spinal cord or nerve root pathology and require a substantial level of medical findings supporting their unequivocal manifestation beyond mere subjective perceptions or complaints.

Diagnosis, surgical procedures or clinical tests are not the key in the rating determination of a back disability. *Functional Impairment* is the key. A laminectomy or a spinal fusion does not in itself produce a specific rating. *It is the restriction of physical activity that is significant.*

For the **Upper Extremities,** preclusions pertain to movement, manipulation, dexterity, pinching, grasping, gripping, torquing, pushing, pulling, repetitive movement, carrying, lifting, positional placement, exertion or other activities of comparable physical effort. The preclusions are due to limitation of motion, neurological/sensory impairments, instability, weakness, atrophy, diminished endurance, acquired sensitivities, need for external helping devices such as a splint, with the ultimate value based on the amputation of the joint/extremity.

A physician can express "loss of work capacity" by referring to the "percentage loss of function" or "proportionate loss of ability to perform specific functions" dealing with the frequency of movement, manipulation, dexterity, pinching, grasping, gripping, torquing, pushing, pulling, repetitive movement, carrying, lifting, positional placement, exertion or other activities of comparable physical effort. Since they are not otherwise meaningful in determining residual permanent disability, Work Capacity Preclusions should be based on percentages of functional loss, rather than referring to limitations based on time or duration of an activity or an inability to lift specific weights.

For the **Lower Extremities,** functional loss pertains to weight-bearing activities derived from the primary anatomical function of the lower extremities that involves the support of the full weight of the body by the legs. Weight-bearing preclusions include such activities as standing, walking, squatting, kneeling, crouching, crawling, pivoting, climbing, and walking on uneven ground or other activities of comparable physical effort. [The Schedule, page 2-19]

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cont'd from p. 3-- Conflict

Consider this dilemma for the physician who assumes dual responsibilities: The doctor treated a patient who, following a routine office visit, advised the doctor in confidence that he had tested positive for the Human Immunodeficiency Virus (HIV). A year later, the same physician is asked to perform a physical exam of this patient on behalf of the employer against whom the patient has filed for a worker's compensation disability, claiming he suffers from work-induced fatigue. During the independent medical exam, the physician is unable to find a link between the patient's job and his claim of fatigue. In his report to the patient's employer, which the physician based both on the current exam and a review of the patient's prior medical record, the doctor speculates that the patient's fatigue might be related to his deteriorating HIV status, and not to his work situation. When the patient learned that the doctor had disclosed information obtained in confidence when the patient was under his care, and which information he had asked the physician not to disclose, he sued the doctor for breach of privacy. The doctor was not aware that in his capacity as an independent medical examiner, he should not have disclosed medical information obtained while the patient was under his care, and which was not discussed during the independent medical exam.

To avoid potential conflicts of this type, physicians should consider declining a request to serve as an independent medical examiner, citing the potential conflict, unless the patient gives the doctor express permission to release all medical information about which the doctor is aware.

cont'd from p. 5 --Permanent

It is the physician's job to focus on the injured worker's loss of function and how it affects the individual's ability to compete in the open labor market. Give the injured worker the benefit of the doubt but don't be fooled into thinking that every subjective complaint should be taken at face value.

Be prepared to change your mind if evidence is presented that contradicts your previous opinions. As the treating or evaluating physician, don't discount the injured worker's complaints even if the surgery or procedure was technically successful. Accurately describe work preclusions and loss of work capacity accurately and don't be concerned that the referral source will be unhappy with you because the rating may come out too high or too low.

If your conclusions are contrary to the belief of the applicant, carefully explain your position in your report as not being a criticism of the injured worker.

Don't be hesitant to recommend treatment, even if expensive, if such care is cost-effective and appropriate and will benefit ("cure or relieve the effects of the injury") assisting the injured worker with pain management and return to gainful employment. On the other hand, question carefully whether treatment being rendered or recommended will really lead to a meaningful difference realizing that much of what physicians offer has the potential for iatrogenic complication and a worsening of the condition.

As pivotal members of the Workers' Compensation Community, physicians have direction under Article 14 of The Claifornia Constitution, to discharge their responsibilities "irrespective of the fault of any party". The determination of permanent disability via the medical report should help accomplish substantial justice in all cases, expeditiously, inexpensively and without circumstance. The medical report should hel;p resolve disputes and not create them by providing unreliable, equivocal or speculative opinions not based on substantial medical evidence.

(Dr. Feinberg has been a QME since 1991)
(Mr. Perez-Cordero is a Permanent Disabilty Ratings Specialist)

cont'd from p. 1-- Pulmonary

Table 4 (Modifying Factors) and 5 (Asthma Equivalent) were removed and replaced with a new Table 4 (Modifying Factors for Asthma).

In addition, on page 3 of the guideline, the paragraph on testing before and after use of a bronchodilator was amended to add a reference to use of albuterol and to allow the physician to test after 10 minutes.

Other changes addressing testing for asthma, discussion of Dco tracings and diffusing capacity were made by the committee. Call the IMC to request copies.

The Council extends its appreciation and thanks to all members of the Internal Medicine subcommittee for their work including Ira Monosson, MD, John O' Brien, MD, Alvin Markowitz, MD, and Harvey Alpern, MD. A special thanks to Dr. Phillip Harber for his exceptional work and contributions to the pulmonary guideline. Thanks also to Dr. Gideon Letz, MD for his review and comments.

QME Providers' List

The following is the most recent list of providers approved by the IMC for QME Continuing Education Courses:

#100**	CA Orthopaedic Asso. (COA) (916) 454-9884
#110	CA Chiropractic Asso. (CCA) (916) 6482738
#120**	David W. O'Brien Attorney at Law (909) 585-7101
#140**	California Society of Industrial Medicine & Surgery (CSIMS) (916) 446-4199
#160	CA Applicants Attorneys' Association (CAAA) (916) 444-5155
#180**	CA Compensation Seminars (818) 349-7853
#210	LA College Of Chiropractic (562) 947-8755
#220	Lerner Education (310) 286-2939
#230	Division Of Workers' Comp. (415) 975-0700
#240	Newton Medical Group (510) 208-4700
#270	Int'l Chiropractors Asso. of CA (ICAC) (916) 362-8816
#290	UCSD Orthomed (619) 625-0084
# 310	CompRite (714) 547-5460
#330	American Academy Of Disability Evaluating Physicians (800) 456-6095
#360	Northbay WC Association (415) 721-0896
#380	Academy Of Forensic & Industrial Chiro Consultants (415) 563-1888
#390***	Learning Edge, Inc. (818) 363-3088
#400	Physician Case Mgmt (PCM) (916) 733-8264
#410	Michael M. Bronshvag, M.D., Inc. (415) 464-0373
#420	UC-Berkeley - Center For Occupational & Environmental Health (510) 231-5645
#450	California Society Of PM & R (510) 537-7873
#460	DIR/ Commission on Health & Safety & Workers' Comp. (415) 557-1304

con't on p. 8

QME Q & A

The following is offered as general information only. It is not intended to serve as legal advice.

Q: As an adjuster, I am unhappy with a QME report and so is the injured worker. Can we get another report?

A: Labor Code §4064 states that the injured worker is only entitled to one QME report at the carrier's expense. However, there is nothing in § 4064 that precludes the carrier from paying for additional reports if it so wishes. If the carrier notifies the IMC that another panel is being requested, the IMC will send the injured worker a replacement name to the existing panel and the worker can select a new QME. Admissibility issues remain with the judge. The first report, of course, must be filed with the WCAB per rule 10622, but if both parties are unhappy with the report, they may stipulate to facts at the MSC that bring to the judge's attention the deficiencies with the report if used as evidence in the case. A party may also request a ratings reconsideration allowing the AD to order a new panel.

Q: How do I pick a continuing education course?

A: The IMC does not make recommendations on courses. We simply approve the course if it meets the criteria set forth in IMC regulation §53. Courses vary by instructor and materials and we suggest you talk to colleagues and to the providers themselves before making a selection. The IMC keeps the course materials for all providers on file at IMC headquarters and QMEs wishing to look at a provider's previous courses, the instructors for the course, the instructor's cvs, price, scheduled dates, etc. may do so during regular IMC office hours. An updated providers' list is included in this edition of *Medically Speaking.*

Q: Under the discussion of voc-rehab, do I need to discuss potential modified/alternate job possibilities?

A: You should *always* discuss modified/alternate job opportunities in your evaluation of an injured worker. Many employers make these positions available as part of a return-to-work program and some have proven quite successful. You do not have to worry about the legal aspects of the alternate or modified job offer (the wages offered, or the length of time the job is expected to last) since that is outside the scope of your evaluation. What you need to comment on is whether the worker can perform the essential functions of the alternate work and what, if any, prophylactic work restrictions may be involved. For certain employers, the ADA may be involved, so your suggestions may provide a resolution in lieu of a formal retraining/rehabilitation program.

Panel request form process misinterpreted by some

Labor Code §139.2 (h) specifically states that the IMC is to issue QME panels in the specialty requested by the injured worker. ***The statute does not allow any other party or physician or government official to make this selection for the worker.*** The IMC however, has received requests from other parties involved with a claim selecting the specialty for the injured worker often for perfectly valid reasons. Although some members of the workers' compensation community have stated that this is a "policy change" by the IMC - it is not. The IMC cannot legally process these requests because the statute clearly states that this is impermissible.

Q: I have struggled mightily with the problem of medical records not being dated. It does not take effort, it does not take anything, except a stamp. The lack of dates on medical records does significantly increase the cost of insurance and the cost of medicine because doctors charge for the time they spend trying to make heads or tails of the records. I know this does not sound like a major problem but I and the others feel that it is, and my efforts have certainly been fruitless.

A: There is currently no provision in the medical-legal fee schedule to compensate physicians for the extra time necessary to "date" the chronology of an injured worker's medical records. The only recourse is under ML 103 and ML 104 which provide for higher reimbursement for services when a variety of factors are met including additional time for records review.

Q: How can I improve my report writing?

A: Read the Physicians' Guide, *especially* Chapters 3 and 6. Highlight material you are having trouble with and whenever you can review it. Like anything else, the more you become familiar with the concepts, the easier it becomes. Also talk to colleagues or anyone in your office who has done report writing. You can always call or send your report to the IMC and speak to our helpful staff. Also, several continuing education providers offer courses and books/audio tapes on report writing.

Q: Once an injured worker selects me as the treating physician, what about notice to the carrier and release forms?

A: DWC regulation 9783 requires the injured worker to notify the carrier as soon as you are selected as the primary treater. As a practical matter however, this is not how the carrier learns about you. Usually, it is the treating physician who notifies the carrier within three days of taking over treatment (DWC regulation 9785). Some physicians go ahead and submit their treatment plan with the notice since they probably have had their initial exam by then.

As far as releases go, the carrier is entitled to any records that may have an impact on the injured workers case regardless of how old the records are. Under section 9783, you may *require* the injured worker to sign a release form allowing you to submit specific records and reports to the carrier during the course of the claim. It is never a good idea to use blanket releases since there may be special considerations - i.e. unrelated matters that have no bearing on the case - that are protected under privacy laws. If you are unsure as to these issues, discuss them with the injured worker. A carrier may subpoena records but a subpoena will not be enforced by the board without valid justification or the records are unrelated to the claim.

In represented cases, this is a matter for the attorneys to work through. In our system of law, it is the judge who decides whether a certain record should remain private. Remember, when you are acting as a treater, your role is to provide treatment to "cure or relieve" the effects of the injury. You should not become an advocate on behalf of the injured worker on legal issues. If there is a dispute and the injured worker is unrepresented, you may direct them to the local information and assistance officer for help. Chapters 7 and 8 of the Physicians' Guide have more information in this area.

The Privacy Rights Clearinghouse, a nonprofit organization, also may provide assistance (619) 298-3396.

cont'd from p. 6 - Providers'

#470 Livingstone-Lopez Consulting (760) 944-6769

#480 Osteopathic Physicians & Surgeons Of California (OPSC) (916) 447-2004

#490 Glenn A. Ocker, D.P.M. (909) 985-1831

#520 Insurance Educ'l Asso. (IEA) (800) 655-4432

#540 Industrial Claims Asso. (ICA) (415) 986-2011

#550 Parkside Acupuncture (415) 665-7682

#560 St. Francis Memorial Hospital (415) 353-6000

#570 Dean Falltrick, D.C. (530) 269-1128

#580 Industrial Medicine Seminar (650) 571-8143

#600 Academy For Chiropractic Education

#620 Law Office of Richard L. Montarbo (916) 221-6193

#660 Blue Cross & Unicare (714) 429-2796

#670 State Comp. Insurance Fund (415) 565-1147

FAX ON DEMAND

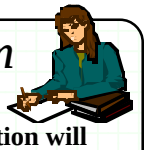
Telephone # (650)737-2063 or 1(800)794-6900 ext. 2063

Forms and Course information for doctors press 1
Forms for an injured worker press 2
Agendas for IMC's monthly public meetings press 3
For a list of approved guidelines press 4
For IMC's Newsletter press 5
To receive a directory of available faxes press 6
To reach an operator press 0
When calling from outside the 650 area code enter 1
and your area code along with your fax number to receive a fax

#680 Mitchell J. Pearce, DC. MS, L.Ac - Acupuncture, Chiropractic & Nutrition Clinic (408) 293-3883

#690 American College Of Chiropractic Orthopedists (909) 674-7853

QME Exam Notice



The QME examination will be held on 9/19/98
The application form was sent out the first week of June.
The cut-off date to submit the application is 8/20/98
For more information, contact Joanne Van Raam at (650) 737-2004

#700 Landmark Healthcare (916) 569-3347

#710 Westshore Lien Management (916) 887-7400

#720 California Acupuncture Medical Association (714) 638-2922

#730 Professional Psych Seminars (818) 707-9115

#740 University of California-Davis (530) 757-8824

#750 Orusa, Inc. (310) 360-0980

****AUDIO COURSE**

***** COMPUTER CLASS**

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